Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001142	A. BUILDING _____ B. WING _____	C 07/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00110040. Complaint IN00110040 -- Unsubstantiated due to lack of evidence. Survey date: July 5, 2012 Facility number: 001142 Provider number: 001142 AIM number: n/a Survey team: Penny Marlatt, RN Census bed type: Residential: 20 Total: 20 Census payor type: Medicaid waiver: 9 Other: 11 Total: 20 Sample: 3 Pine Knoll Assisted Living Center was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00110040. Quality review completed 7/6/12 Cathy Emswiller RN	R 000		